RI 79-2/989

Information for Civil Service Retirees and Survivor Annuitants About the Federal Employees Health Benefits Program

This pamphlet has important information about the Federal Employees Health Benefits (FEHB) Program for:

- Civil Service Retirees
- Widows, Widowers, and Children of Deceased Federal Employees or Civil Service Retirees
- Former Spouses of Federal Employees or Civil Service Retirees (Whose Marriages Terminated Before the Employees' or Retirees' Deaths)

Your plan's brochure has detailed information about your health benefits coverage. Keep the brochure and this pamphlet handy and refer to them if you have a question.

This pamphlet reflects legislation and regulations in effect through August 1987.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

RI 79-2
Revised June 1989

Previous editions are usable

PM 1.10:

READEX FICHE best copy available

IMPORTANT

Whenever you write to the Office of Personnel Management (OPM), be sure to sign your name and give us your retirement claim number (CSA number) and your date of birth. If you are a survivor annuitant, provide the name of the former Federal employee on whose service your annuity is based, as well as your survivor annuity claim number (CSF number). In addition, if you are a former spouse of a Federal employee and you are paying health benefits premiums directly to OPM, you should also provide your Social Security number.

If someone is writing to OPM on your behalf, we still must have **your signature** in order to provide information about your health benefits coverage or to take any action regarding your enrollment. If you become unable to manage your affairs due to a mental or physical disability, your guardian or other person responsible for your care and custody should immediately notify:

OPM
Employee Service and Records Center
Boyers, PA 16017.

He or she should provide your full name and your retirement or survivor annuity claim number.

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Types of Enrollments

There are two types of enrollment in each plan--

1. SELF ONLY--This enrollment provides benefits only for you.
2. SELF and FAMILY--This enrollment provides benefits for you and for all eligible members of your family.

Who Is Covered Under a Self and Family Enrollment

If You Are a Civil Service Retiree

A Self and Family enrollment covers you, your spouse, and your unmarried dependent children under age 22 (see below for information on disabled children), including your legally adopted children and recognized children born out of wedlock. Your stepchildren and foster children also are included if they live with you in a regular parent-child relationship. (Your stepchildren and foster children may receive health benefits coverage after your death only if they were living with you in a regular parent-child relationship at the time of death.)

Other relatives, such as parents or a grandchild (unless the grandchild qualifies as a foster child, see below), are not eligible for coverage as family members even if they live with and are dependent on you.

Disabled Children Age 22 and Over

An unmarried child incapable of self-support because of a disability which began before age 22 (and which is expected to last at least one year) may continue to be covered as a family member after reaching age 22. If you have a child so disabled and have already established the fact with your former employing office, you need take no further action unless we ask for another medical certificate.

If you have a child so disabled but have not yet established that fact, you should inform us by writing to:

OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044,

about 90 days before the child's 22nd birthday or as soon as possible thereafter. Your notification must include a medical certificate which contains the following:

1. your name and Civil Service retirement (or survivor annuity) claim number;
2. the name and date of birth of the child;
3. the nature of the disability:
4. the period of time the disability has existed;
5. the probable future course and duration of the disability;
6. a brief educational and employment history for the child; and
7. the doctor's signature, name, address, and telephone number.

Foster Children

A foster child for health benefits purposes is a child you are raising as your own, who lives with you, and for whom you have assumed full parental responsibility and control. There must be an expectation that you will continue to raise the child into adulthood. A child temporarily living with you is not a foster child; neither is one placed in your home by a welfare or social service agency which retains control of the child and pays for maintenance. (Note: If one or both of the child's natural parents also lives with you, a foster parent-child relationship between you and the child would not ordinarily be considered to exist.)

New Family Members

If you have a Self and Family enrollment, any new family member--such as a new spouse if you are a retired employee (not a survivor annuitant)--is automatically covered by your health benefits plan. You need take no action to include your spouse in your enrollment. However, if you submit a claim for medical expenses for your new spouse, your plan may ask for proof of termination of the previous marriage (if applicable) and your remarriage, and the name and date of birth of your new spouse so they can update their records.

If you are enrolled for Self Only and acquire a new family member, you may change to a Self and Family enrollment as shown on page 12.

If You Are a Widow(er) Survivor Annuitant

A Self and Family enrollment provides coverage for you and all eligible family members of the deceased employee or retiree, as described above. If you remarry before age 55, your coverage will terminate (see page 16). If you remarry on or after age 55, your

coverage will continue, but your new spouse and his or her dependents cannot be included in your enrollment. However, if you are also receiving an annuity as a civil service retiree based on your own Federal career, you may be eligible to transfer the enrollment to your retirement annuity in order to cover your new spouse and his or her eligible children. If you wish to do so, you should send a written request (being sure to provide your retirement and survivor annuity claim numbers) to:

OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044.

We will determine if you are eligible to transfer your enrollment after we receive your request. The request must be filed within 31 days before to 60 days after the date of marriage.

If You Are a Former Spouse Survivor Annuitant

If you have FEHB coverage as a former spouse (i.e., your marriage terminated before the employee's or retiree's death), a Self and Family enrollment covers you and any unmarried dependent child or adopted child under age 22 of you AND the employee or retiree. (See **Disabled Children Age 22 and Over,** page 4 if applicable.) If you remarry, your new spouse and his or her children cannot be included in your enrollment. If you remarry before age 55, your enrollment will terminate (see page 16).

When a Family Member Loses Eligibility for Coverage

- Your spouse will lose eligibility for coverage under your Self and Family enrollment upon divorce or annulment of the marriage. (However, certain former spouses may be eligible to enroll in an FEHB plan.)

- A child under age 22 loses eligibility for coverage at marriage or attainment of age 22, whichever occurs first. Children whose marriage ends in divorce or annulment before they reach age 22 again become eligible for coverage from the date of the divorce or annulment until they reach age 22.

- A disabled child age 22 or over loses eligibility for coverage at marriage or recovery of ability for self support.

If your family member loses eligibility for coverage for any of the above reasons, his or her coverage will continue temporarily for 31 days after the terminating event. During this 31-day period, the family member can convert to a nongroup contract offered by your insurance carrier--see page 18.

NOTE: If you have a Self and Family enrollment, your monthly premium is the same amount regardless of the number of family members covered by the enrollment. Therefore, if a family member loses eligibility for coverage, your premium is not reduced. However, if you become the only person eligible for coverage, you should immediately notify:

OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044,

so your enrollment can be changed to less expensive Self Only coverage.

How the Cost of Your Coverage Is Determined

If you are a civil service retiree, a widow(er) survivor annuitant, or a child of a deceased Federal employee or retiree whose enrollment is in your own name, you and the Government share the cost of your premiums. The Government pays 60 percent of the average high option premium of six of the largest health benefits plans available through the Federal Employees Health Benefits Program, but not more than 75 percent of the total premium for any plan. You pay the remainder of premium costs. If you receive health benefits coverage as the former spouse of an employee or annuitant, you pay the full cost of the premium (both the annuitant and the Government share).

Generally, you will see a change in your monthly premium rate effective January 1 of each year even if you do not change your coverage. This change will first be reflected in your payment dated February 1, which pays annuity and insurance premiums for the month of January.

Changing Your Enrollment

Factors to Consider When Changing Your Enrollment

Because health insurance needs vary with each person, the Office of Personnel Management cannot provide specific advice on what plan or enrollment is best for you. You should consider the composition of your family, your financial situation, the condition of your health and your medical needs, as well as the health of any eligible family member, and your eligibility for Medicare (see page 20), when deciding what coverage is best in your particular situation. You should also consider what type of plan (Fee-for-Service or Prepaid, explained below) is best for you and your family. You should compare the benefits offered by the plans available to you.

Each plan has a brochure that describes its benefits. You can obtain these brochures by writing to the particular plan in which you are interested. Do not write to OPM for a brochure because they are not available at OPM. However, you can obtain a Plan Comparison Chart by writing:

OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044.

The Plan Comparison Chart provides general information about the major features of each plan in the FEHB Program. However, before you make a final decision about changing plans, you should carefully review the official brochures for the plan or plans in which you are interested.

When comparing plans, remember that the true cost of your health care protection includes both the premiums and your out-of-pocket costs for any of the following:

- deductibles (the amount of covered charges you must incur before the plan pays benefits),
- coinsurance (a percentage of covered charges you must pay for a service or benefit provided by the plan),
- copayments (a fixed dollar amount you must pay for a service or benefit provided by the plan), and
- examinations and other physician services, laboratory tests, and prescription drugs, etc.

Your total cost of protection also depends on other factors, such as the extent to which the costs of services are paid by a plan based on "customary and reasonable charges" or a "scheduled allowance." A customary and reasonable charge is the amount a provider normally charges for a particular service and which is usually charged by most other providers for the same service in the same geographic area. When a plan sets the customary and reasonable charge as the maximum payment for a service, you must pay any amount above that. A scheduled allowance specifies the maximum amount that a plan will pay for a particular procedure regardless of the amount your provider charges you.

What Types of Plans Are Available

In general, there are two types of health benefits plans under the Federal Employees Health Benefits Program:

Fee-for-Service Plans

These plans reimburse you or the health care provider for covered services. If you are enrolled in one of these plans, you may choose your own physician, hospital, and other health care providers. Fee-for-Service plans include the Blue Cross and Blue Shield Service Benefit Plan, the Aetna Indemnity Benefit Plan, and plans sponsored by unions and employee organizations.

The Blue Cross and Blue Shield Plan and the Aetna Plan are open to all annuitants. Some employee organization plans are open to all annuitants through full or associate memberships in the organizations that sponsor the plans. Other employee organization plans are restricted to annuitants who are full members of the sponsoring organization. (If you are a former spouse survivor annuitant, however, you can enroll in one of these restricted employee organization plans if you were entitled to coverage as a family member in that plan prior to the dissolution of your marriage.) You should check the plan's brochure to see if its membership is restricted. Generally, the employee organizations require you to pay membership fees or dues in addition to your health benefits premium. These membership charges are paid directly to the employee organizations and are not part of the Federal Employees Health Benefits Program.

If your membership in the employee organization is discontinued, your enrollment in the plan will be terminated. The employee organization will send you a

notice of the termination. You should request enrollment in another plan as soon as you receive this notice. (Your request must be filed within 31 days after your enrollment ends.)

Prepaid Plans

These are the Comprehensive Medical Plans/Health Maintenance Organizations (CMP/HMOs) that provide or arrange for health care by designated plan physicians, hospitals, and other providers in particular locations. CMP/HMOs pay all providers through salaries or other payment arrangements. You pay any required deductibles, coinsurance, and copayments.

Each CMP/HMO is open to all annuitants who live within the plan's enrollment area. Contact the plan directly or refer to its brochure if you have any questions about the enrollment area. Be sure that you are living in the enrollment area before changing to a CMP/HMO. If you are enrolled in a CMP/HMO and move out of the enrollment area, you should request to be enrolled in another plan as soon as possible after you move. Also, if you receive health care from a nondesignated physician, hospital, or other provider, your claims may not be allowed.

Events Which Allow You to Change Your Enrollment

You may voluntarily cancel your enrollment, or change from Self and Family to Self Only, at anytime. However, if you cancel your enrollment, you and any family members covered under your enrollment will not be able to convert to a nongroup contract (see page 18). (A surviving child who loses coverage under another survivor annuitant's enrollment because of cancellation or a change to Self Only may, if eligible, enroll in his or her own right.)

If you, as a civil service retiree or widow(er) survivor annuitant, cancel your enrollment, you **cannot** later reenroll in an FEHB plan unless you have had continuous FEHB coverage under another person's enrollment during the time between your cancellation and reenrollment. In other words, if you decline or cancel FEHB **because you are covered under another individual's Self and Family FEHB enrollment**, and you later lose this coverage as a family member, you may be eligible to reenroll in the FEHB Program. (Note: If FEHB eligibility is based on entitlement to benefits as a former spouse, cancellation permanently bars FEHB reenrollment.)

In addition, if you are a retired employee who loses FEHB coverage as a family member (because the enrollment is canceled or changed to Self Only coverage), you may enroll in the FEHB Program in your own right only if:

- You retired on an immediate annuity (one that begins within one month after your separation from the service); and,
- Prior to your retirement, you had continuous FEHB coverage (under your own or your spouse's enrollment) since your first opportunity to enroll or for the five years of service immediately preceding your retirement, whichever is shorter.

In order to reenroll you must apply by writing to the following address **within 31 days** after you lose coverage:

OPM
Insurance Services Section
P.O. Box 14172
Washington, D.C. 20044.

When you apply for reenrollment, be sure to provide your retirement claim number or your survivor annuity claim number and your spouse's full name and social security number with your request. (If your spouse is a civil service retiree, be sure to provide his or her CSA number.)

Note: (a) If you cancel FEHB coverage in your own right because you are covered under **non-FEHB** health insurance, you cannot later reenroll as a civil service retiree or survivor annuitant.

(b) If a family member covered under your Self and Family enrollment is also a Federal employee and loses coverage under your enrollment he or she may be eligible to enroll in a health benefits plan and should contact his or her agency for information.

You may make other changes in your enrollment only on specified occasions and within certain time limits as explained on pages 12 and 13.

Events Which Permit Change	From Self Only to Family	From One Plan or Option to Another	Time Limit In Which Election to Change Must Be Filed With OPM
Open Season.*	Yes	Yes	As announced by OPM.
Change in retiree's marital status.	Yes	Yes	From 31 days before to 60 days after change in marital status.
Other change in family status (For example, birth of a child).	Yes	No	Within 60 days after the event.
You're enrolled in a comprehensive plan(CMP/HMO) and move from the area it serves.	Yes	Yes	Anytime after you move.
Your enrollment in an employee organization plan is terminated because the plan terminates your membership.	No	Yes	Within 31 days after your enrollment ends.
Your plan stops participating in the FEHB Program.	Yes	Yes	As set by the Office of Personnel Management.
Retiree's federally employed spouse is enrolled for Self Only but loses this coverage because his or her agency terminates the enrollment.	Yes	No	Within 31 days after spouse's enrollment is terminated.
You become eligible for Medicare.	No	Yes	30 days before you become eligible for Medicare or any time thereafter.
Your eligible child(ren) loses coverage under someone else's enrollment under the FEHB Program.	Yes	No	Within 31 days after the child loses coverage.

Also, see Note on page 11.

* OPM will mail Open Season information to you before this event occurs. Therefore, you must always notify OPM if your correspondence address changes so you can receive this important information. To do so, write OPM, Change of Address Section, PO Box 686, Washington, D.C. 20044. Be sure to provide your retirement or survivor annuity claim number, your new address, and your signature.

How to Change Your Enrollment

To change your enrollment, you must write to:
OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044.

Be sure to give your civil service retirement number or your survivor annuity claim number if you are a survivor annuitant. (If you are a former spouse of a Federal employee and you are paying health benefits premiums directly to OPM, you should also provide your Social Security number.) You should state exactly the change you wish to make, the event which permits the change, and the date on which that event occurred. If you are **canceling** your enrollment, before we can process your request, we will send you a letter which must be signed and returned to us, unless your **signed** request includes the following:

1. a statement that you understand you are not entitled to a 31-day temporary extension of coverage, and
2. a statement that you understand you cannot reenroll in any plan under the FEHB Program at a later date. (However, if you are canceling because you are covered under your spouse's Self and Family enrollment, you may be eligible to reenroll as discussed on page 10.)

Effective Dates for Enrollment Changes

Except for an Open Season enrollment change, the effective date of the changes shown on pages 12 and 13 generally will be the first day of the month **after** the one in which we receive your request for a change. (For example, if we receive your request to change to Self Only coverage on May 5, the effective date for the change is June 1.)

However, if you requested the cancellation of your enrollment, and your properly completed request is received on or before the 15th day of the month, the cancellation is effective at the end of that month. If your properly completed request is received after the 15th day of the month, it is effective at the end of the following month. (For example, if we receive your properly completed cancellation request on June 5, the effective date is June 30; if we receive your properly completed cancellation request on June 19, the effective date is July 31.) When you look for your

premiums to change, remember that the annuity payment you receive on the first business day of the month pays your annuity and insurance premiums for the previous month.

Continuation of Coverage for Survivors After Enrollee's Death

If you should die while enrolled for Self and Family, all survivors who meet the definition of "family member" will automatically be able to continue your enrollment as long as any one of them receives a survivor annuity. Their share of the cost of the plan will be deducted from their annuity payment. If there is only one survivor annuitant and no other family member is eligible for continued coverage, the enrollment will be changed automatically to the less expensive Self Only coverage.

Widow(er) Survivor Annuitants Who Are Also Federal Employees

If you are a widow(er) who is, or becomes a Federal employee, and you elect to enroll in a plan as an employee, immediately notify the Office of Personnel Management to cancel your survivor annuitant enrollment. (You cannot be enrolled twice). If your enrollment as a Federal employee terminates for any reason (other than by cancellation), it may be reinstated as a survivor annuitant enrollment if you are still receiving an annuity. To request such reinstatement, write to:

OPM
Insurance Services Section
PO Box 14172
Washington, D.C. 20044.

Give the name and address of your last employing office, and your survivor annuity claim number (CSF number). You should also provide copies of your health benefits registration forms (SF 2809 and SF 2810) with your request for reinstatement. If we receive your letter within 60 days after your separation, your reinstatement will be effective on the day after your enrollment terminated. If your letter is received more than 60 days after your separation, your reinstatement will be effective on the first day of the month after we receive your letter.

What Events Terminate Health Benefits Coverage

If You Are a Civil Service Retiree

If your annuity terminates (for example, when a disability retiree recovers or is restored to earning capacity), your enrollment will automatically end on the last day of the month for which you are entitled to an annuity. However, coverage will be temporarily extended for 31 days (see page 18).

If you are a disability retiree whose annuity terminated as described above, you will retain your health benefits coverage if you are entitled to and apply for an immediate discontinued-service annuity. You will receive complete information concerning your right to do so if your disability annuity terminates.

If you are under age 60, and your disability annuity is reinstated (after December 31, 1983) due to loss of earning capacity or a recurrence of the disability for which you retired, you will be given an opportunity to have health benefits coverage reinstated if you were enrolled at the time your disability annuity previously terminated.

If you are entitled only to a deferred annuity beginning at age 62 after your disability annuity terminates, you cannot retain your health benefits coverage as a civil service retiree.

Under certain conditions, your annuity will terminate if you are reemployed in the Federal service. If this occurs, your health benefits enrollment will be transferred to your employing agency. If you are so reemployed, you should immediately notify:

OPM
Employee Service and Records Center
Boyers, PA 16017.

Be sure to refer to your civil service retirement number (CSA number) and provide us with a copy of the personnel document showing your appointment, if possible, or the full name and address of your employing agency.

If You Are a Widow(er) or Former Spouse Survivor Annuitant

If you remarry before age 55, your survivor annuity and health benefits enrollment will end on the last day of the month preceding the month in which you remarry (subject to the temporary extension of coverage, see page 18). If you are enrolled in Self and Family coverage, the enrollment will automatically continue for any eligible children as long as one of them receives a survivor annuity (but you will not be covered). If you remarry before age 55, you must immediately notify:

OPM
Employee Service and Records Center
Boyers, PA 16017.

Be sure to provide us with a copy of your marriage certificate and refer to your survivor annuity claim number (CSF number). If you remarry after age 55, your survivor annuity and health benefits coverage will continue; however, your new spouse and his or her children cannot receive health benefits coverage under your survivor annuitant enrollment. (However, if you are a widow(er) survivor annuitant who is also receiving an annuity based on your own Federal career, you may be eligible to transfer your enrollment to your retirement annuity in order to provide coverage for your new spouse and his or her children, see page 5 for information.)

If you are receiving health benefits coverage as a **former spouse**, your coverage will also terminate if:

1. You lose entitlement to survivor annuity benefits under the terms of the court order which provided your benefits, if applicable, or
2. You do not pay the full cost of the enrollment by the payment due date (if premiums are not being withheld from your survivor annuity).

If you are a **widow(er)** whose annuity and health benefits coverage terminated due to remarriage before age 55, see below for information on how your coverage and annuity can be reinstated if the marriage ends. If you are a **former spouse** whose annuity and health benefits coverage terminated due to remarriage before age 55, your survivor annuity and health benefits coverage **cannot** be reinstated if your marriage ends.

Reinstatement of Widow(er)'s Health Benefits Coverage If Remarriage Ends

If you remarry before age 55, your survivor annuity and health benefits coverage terminate at the end of the month preceding the one in which you remarry. If your remarriage ends due to death, divorce, or annulment, your survivor annuity will be reinstated after we receive proof of the termination. If you had health benefits coverage on the date your annuity previously terminated due to remarriage, you will be given the opportunity to reenroll in a Federal health benefits plan when your survivor annuity is reinstated. You should immediately notify:

OPM
Employee Service and Records Center
Boyers, PA 16017,

if your remarriage terminates and furnish proof of the termination. You should also be sure to refer to your survivor annuity claim number (CSF number) and the full name of the deceased employee or annuitant on whom your benefits are based.

If Health Benefits Coverage Ends

Temporary Extension of Coverage

Your coverage will continue temporarily for 31 days after your enrollment ends for any reason except voluntary cancellation. If you are confined to a hospital on the 31st day of your temporary extension, your benefits will continue while you are confined, up to a maximum of 60 additional days. These temporary extensions are without cost to you. They also apply to any family member who loses coverage under your enrollment for any reason except your voluntary cancellation of the enrollment.

Conversion to a Nongroup Contract

If you are:

- a civil service retiree,
- a widow or widower survivor annuitant,
- a former spouse survivor annuitant, or
- a child of a deceased Federal employee or civil service retiree who has coverage under the FEHB Program in your own name,

and your enrollment terminates for any reason other than by your voluntary cancellation, you are entitled to a non-group health benefits contract issued by the

carrier of the plan in which you were enrolled. Nongroup conversion policies are issued without evidence of insurability. You must pay the entire premium for a nongroup contract.

Normally, within 60 days of the date your enrollment terminates, OPM will send you a notice of the termination and your right to convert. (Note: This does not apply to family members who lose eligibility for coverage under a Self and Family enrollment, see below.) If you are interested in conversion, you must apply to the nearest office of your plan for information about the nongroup contract within 31 days of the date of the termination notice.

If the notice of termination is not sent to you within 60 days of the date your enrollment ends, or you are unable for reasons beyond your control to make a timely request for conversion, you may make a belated request by writing directly to your carrier within 6 months after your enrollment ended. You must also provide proof that your entitlement to coverage ended. (For example, you should submit a copy of your marriage certificate if you are a widow(er) or former spouse who lost coverage because of remarriage before age 55.) You must also show that (1) you were not notified of the termination of your enrollment and your right to convert, and were not otherwise aware of it, or (2) that you were unable to convert for reasons beyond your control.

If you make a belated request for conversion as described in the preceding paragraph, the health benefits carrier will determine if you are eligible to convert to a nongroup contract. If you are eligible to convert, you must do so within 31 days after receiving the carrier's notice of your right to convert. If the carrier determines that you are not eligible to convert, you may request OPM to review that decision by writing.

OPM
Office of Insurance Programs
Retirement and Insurance Group
P.O. Box 436
Washington, D.C. 20044.

If a member of your family loses eligibility for coverage under your Self and Family enrollment (as for example, when a child reaches age 22 or you are divorced from your spouse, see page 6), that family member is entitled to convert to a nongroup contract with the plan during the 31-day temporary extension of coverage period described on page 18. **You won't be**

notified by OPM when a family member loses eligibility. The affected family member also won't be notified by OPM that he or she is no longer eligible for health benefits coverage. Therefore, when this occurs, and if the affected family member wants to convert, he or she should apply, within 31 days after eligibility for coverage ends, to the nearest office of the plan in which you are enrolled for information about a nongroup contract. However, if a family member loses coverage because you cancel your enrollment, he or she cannot convert to a nongroup contract.

The effective date of the conversion contract is the day after the 31-day temporary extension of coverage period expires. You must pay the premiums due for any retroactive period under the conversion contract.

Note: Many plans do not provide the same benefits under the converted nongroup contract that they provide under the Federal employee group plan, and the premium rates for converted nongroup contracts are generally higher because there is no Government contribution towards the cost of the enrollment. This may be an important consideration if you are thinking of changing plans and have a family member who will lose coverage at some time in the near future. If you need to know the benefits and cost of the converted nongroup contract, get in touch with your plan.

How Medicare Affects Your Health Benefits Coverage

Because many people covered by FEHB plans also have Medicare coverage (or other group health insurance or no-fault automobile protection) all FEHB plans have a coordination of benefits (COB) or double coverage provision. The purpose of this provision is to enable enrollees and covered family members to recover as much of their health care expenses as their total coverage permits, but not more than the actual charges for the care. Under the COB, or double coverage provision, one plan normally pays its benefits in full as the **primary payer** and the other plan pays a reduced benefit as the **secondary payer.**

If you have Medicare and you (1) are age 65 or over and (2) are not employed in the Federal service, Medicare is the primary payer of your health benefits expenses and your FEHB plan is the secondary payer. Medicare is also the primary payer if you are age 65 or over and are enrolled in Medicare Part B (Medical Insurance) only, regardless of your employment status. If you are a Federal retiree with Self and Family coverage and your covered spouse is age 65 or over and has Medicare coverage, Medicare is the primary payer of your spouse's health benefits expenses unless you or your spouse are employed in the Federal service and your spouse has Medicare Part A (Hospital Insurance).

Note: The Health Care Financing Administration (HCFA), which administers Medicare, has determined that the following information applies if you or a covered family member are under age 65 and are eligible for Medicare benefits on the basis of disability:

- If you are employed in the Federal service, your FEHB plan is the primary payer of health benefits expenses and Medicare is the secondary payer of benefits.
- If you are not employed in the Federal service, Medicare pays conditional primary benefits and your FEHB plan is the secondary payer of benefits.

Contact your local Social Security Administration office for assistance if you have any questions concerning whether your FEHB plan or Medicare is the primary payer of your or a covered family member's health benefits expenses.

All FEHB plans will adjust any benefits payable so they supplement rather than duplicate Medicare benefits. If Medicare is the primary payer, it will generally pay its allowable benefits in full and your FEHB plan will pay a reduced benefit as the secondary payer. The combined amount paid by both plans will usually equal 100% of covered, or allowable, expenses. Although 100% of covered or allowable expenses may be paid, there may be remaining medical expenses incurred which are not covered by either Medicare or your health benefits plan. **You are responsible for paying any noncovered expenses.** You should consult your Medicare handbook (available from the Social Security Administration) and your health benefits plan brochure for information about covered and noncovered expenses.

If Medicare is the primary payer of claims for health expenses, you must first submit your claim to Medicare for payment consideration. This is so because your health benefits plan cannot process a claim until after Medicare has paid any covered expenses. Always submit the Explanation of Benefits you receive from Medicare to your FEHB plan along with your claim.

If you (and your spouse) have both parts of Medicare (Part A Hospital Insurance and Part B Medical Insurance) and you are also in a high option (or a plan with only one option), you may be paying for more coverage than you need. You may wish to consider changing to a less expensive plan or option. Generally, the standard options (or a plan with only one option which is comparable to a standard option) adequately supplement both parts of Medicare at less cost to you than the high options. If your spouse or other eligible family members do not have both parts of Medicare, you may need a high option Self and Family enrollment to protect them even though you may not need that much coverage.

Note: The monthly premium for your health benefits enrollment is not reduced if you (or your spouse) have Medicare coverage. However, you can change your enrollment to any option of any plan (for which you are eligible) beginning on the 30th day before you become eligible for Medicare.

Medicare Premiums

OPM can withhold monthly premiums for Medical Insurance (Part B of Medicare) from your annuity under certain conditions. You should contact your local social security office (not OPM) if you want Medicare premiums withheld from your annuity. (You will need to provide them with your CSA or CSF number.) If you are eligible, your local social security office will notify the Social Security Administration headquarters in Baltimore, Maryland, which will notify OPM to begin withholding premiums from your annuity. We can take no action to withhold these premiums (or to cancel Medicare premiums being withheld from your annuity) unless we are notified to do so by the Social Security Administration's headquarters in Baltimore. You should always contact your local social security office if you have any questions concerning this matter.

How to File Claims for Medical Expenses

Refer to your health benefits brochure for instructions on completing and submitting claims to your plan for payment consideration. Your completed claim form should not be sent to OPM. If you need claim forms, you may obtain them by contacting your health benefits plan.

If Your Claim for Medical Expenses Is Denied

If a claim (or portion of a claim) for payment or service is denied, your plan will reconsider its denial if you submit your written request for reconsideration within one year after the date of the notice denying your claim. Your request should state, by referring to applicable provisions in the plan's brochure, the reasons why you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receiving your written request for reconsideration your plan must:

1. affirm its denial in writing to you, or
2. pay the claim or provide the service, or
3. request additional information from you or the provider of services reasonably necessary for making a decision. Your plan must notify you if it has requested additional information from your provider of services. (If your plan has requested additional information and it is not submitted within 60 days, the plan will base its decision on the information it has on hand.)

If your plan affirms its denial of your claim for payment or services or fails to respond to your written request for reconsideration within 30 days after the plan received (1) your reconsideration request or (2) any additional information it requested, you may ask OPM for a review. If your request for review is timely (as discussed below), OPM will determine if your plan acted in accordance with its contract. Your request for OPM's review should be sent to:

OPM
Office of Insurance Programs
Retirement and Insurance Group
P.O. Box 436
Washington, D.C. 20044.

In order to be timely, you must send your request for review in time for OPM to receive it as specified below:

- If your request for review is based on the plan's affirmation of its denial, your request must be received by OPM within 90 days of the date the plan notified you of its decision.

- If your request for review is based on the plan's failure to respond within 30 days after it received (1) your request for reconsideration or (2) any additional information it needed, your request for review must be received by OPM within 120 days after the date of your request for reconsideration or the date you were notified that the plan needed additional information.

How to Obtain a Health Benefits Identification Card

OPM does not provide health benefits identification cards. If you have lost your ID card, you must contact your health benefits plan for a replacement. If you change your enrollment or change plans, your plan will send you a new identification card. This generally takes 60 to 90 days from the date you receive OPM's notice that we have processed your change.

If you should need health services before you receive your new ID card, you may show the OPM notice you received to the doctor or hospital to verify your new enrollment. Be sure to refer to your social security number and date of birth when contacting your plan. If you are a survivor annuitant, you should also refer to the full name of the deceased employee or annuitant on whose service your benefits are based and give his or her social security number and date of birth.

Special Information for Compensationers

If your civil service annuity has been suspended because you are eligible for and are receiving compensation benefits from the Office of Workers Compensation Programs, U.S. Department of Labor, you must contact your compensation office if you want to change or cancel your health benefits enrollment. That office maintains your health benefits enrollment. If your compensation terminates and you are eligible to have your civil service annuity reinstated, your health benefits enrollment will be transferred to OPM and premiums for your enrollment will be withheld from your reinstated annuity.

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